SPECIAL TRANSPORTATION SERVICE (STS) APPLICATION FORM

I. APPLICANT SECTION:

S.S.#:(9 digits) __ __ __ - __ __ - __ __ __ __ Date of Birth: ___ / ___ / ___ Sex: [ ] Male [ ] Female

Last Name:_____ First Name: _____ M.I.: _____

Street Address:_____ Apt.#: _____

City: _____ State: _____ Zip Code: _____ Home Phone:( )_____

Is this a [ ] House [ ] Apartment [ ] Nursing Home [ ] ACLF [ ] Boarding Home

Applicant's weight:_____lbs. Wheelchair:(if applicable) weight _____lbs, length_____ , width_____.

EMERGENCY CONTACT: Name and telephone number of someone we can call in an emergency.

Name:_____ Relationship:_____ Phone:( )_____

ETHNICITY: *(for statistics only, optional)*
[ ] White Non-Hispanic [ ] Black Non-Hispanic [ ] Hispanic [ ] Other *(specify)* _____

A. If you use a wheelchair, can you transfer with minimal assistance into a sedan?_____Yes _____No
Type of wheelchair: [ ] Manual [ ] Motorized [ ] Scooter *(Three wheeled)*

B. If someone assisted the client to complete this form, please specify;

Name:_____ Relationship:_____ Phone:( )_____

If you need to have information given to you in an accessible format, please check one:
[ ] Braille [ ] Large Print [ ] Audio [ ] Computer Disk (ASCII)

II. APPLICANT'S RELEASE:

The following information is requested to determine when and under what circumstances the applicant can use the County bus, rail, or mover service and when Special Transportation Service (STS), van/sedan shared-ride paratransit service, is required.

I understand that the purpose of this form is to determine if I am eligible for Miami-Dade Transit Ageny's (MDT) Special Transportation Service (STS) in accordance with the American with Disabilities Act (ADA) of 1990 complementary paratransit service requirement. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as prosecution to the maximum extent allowed by the laws of the State of Florida. I hereby authorize my medical representative to release any and all information required by the MDT Paratransit Certification Enrollment Office regarding my medical condition for the purpose of determining my eligibility to use Special Transportation Service (STS).

Applicant's Signature:_____ Date:_____

If applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf.

Signing for applicant:_____ Date:_____

Print Name:_____Relationship to applicant:_____

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III. MEDICAL VERIFICATION *(to be completed by a Florida licensed physician)*

The Americans with Disabilities Act of 1990 (ADA) requires all public entities operating fixed-route transportation service for the general public to also provide complementary paratransit service to persons unable to use the fixed-route system. Miami-Dade Transit (MDT), Special Transportation Service (STS) provides complementary paratransit shared ride (i.e. van/sedan) service to individuals certified as ADA paratransit eligible. The applicant who has asked you to review and sign this form is applying to MDT to be considered eligible for this service. This application form will assist MDT to determine when and under what circumstances the applicant can use Metrobus, Metrorail, or Metromover service and when they require paratransit service. ADA/STS van/sedan shared-ride service is intended only for those trips that the person cannot make on the bus/rail/mover system.

STS Eligibility Criteria:

Applicants shall be individually evaluated, and eligibility shall be determined based on a functional ability to use conventional public transportation: Metrobus, Metrorail, and Metromover. Functional inability to use public transportation includes the Americans with Disabilities Act (ADA) Categories 1, 2, and 3 as described in this application.

A. AMERICANS WITH DISABILITIES ACT (ADA) CATEGORIES:

Check the categories of eligibility that you recommend should apply.

1. [ ] The individual is unable, as a result of a physical or mental impairment *(including a vision impairment)*, and without the assistance of another individual, *(except the operator of a wheelchair lift or other boarding device)*, to board, ride, or disembark from an accessible bus or rail vehicle.
2. [ ] The individual needs the assistance of a wheelchair lift or other boarding assistance device and is able, with such assistance, to board, ride, and disembark from accessible transit vehicles. *(The individual would be eligible if an accessible vehicle is not available.)*
3. [ ] The individual has a specific impairment-related condition which prevents the individual from traveling to or from: Metrobus; Metrorail; and/or Metromover stops/stations.
4. [ ] Check here, if none of these categories apply.

Medical Representative's Letterhead Or Prescription Form Requirement:

In order to process this applicant's request to become a qualified STS rider, we require that the medical certification section of this form be completed, and a letterhead or prescription form with the name and address of both the medical representative and the applicant be attached to this application. To expedite applicant processing, please attach objective medical findings which substantiate the disability. Examples include:

EEG or Neuropsychological Evaluation with FSIQ
Snellen (visual accuity) and/or Perimeter Chart (field of vision) Report(s)
Elisa Western Blot result reading CD4 + counts
X-ray, MRI, or CAT Scan Findings
Respiratory FVC/FEV1

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B. INDICATE THE TYPE AND NATURE OF THE INDIVIDUAL'S DISABILITY(IES).

CHECK AS MANY ITEMS AS MAY BE APPLICABLE. *(SEE STS ELIGIBILITY CRITERIA)*

1. MOBILITY IMPAIRMENT:

a. [ ] Non-ambulatory disability *(requires wheelchair to travel)*. Please specify the condition which requires full time use of a wheelchair _____

b. [ ] Ambulatory disability(ambulation may be limited, but able to walk with or without mobility aid, may use wheelchair but can transfer to a seat with little or no assistance).

I. Amputation *(detail extremity)*: _____

II. [ ] Stroke without Hemiplegia III. [ ] Stroke with Hemiplegia IV. [ ] Brain/Spinal Nerve Trauma

V. [ ] Other: _____

Date disability started: _____ (Please attach EEG or neuropsychological evaluation report)

2. NEUROLOGICAL DISABILITY*(motor dysfunction)*:

(Please attach EEG or neuropsychological evaluation report)

a. [ ] Multiple Sclerosis b.[ ] Epilepsy c. [ ] Muscular Dystrophy d. [ ] Cerebral Palsy

e. [ ] Parkinson's f. [ ] Alzheimer's g. [ ] Other _____

3. VISUAL DISABILITY:

a. [ ] Totally blind

b. [ ] Legally blind, If this person is legally blind complete the following:

Corrected visual acuity: Right Eye_____ Left Eye_____(Please attach Snellen reports both eyes)

Corrected field of vision: Right Eye_____ Left Eye_____(Please attach Perimeter chart reports both eyes)

4. COGNITIVE DISABILITY:

a. Type of mental impairment:

[ ] Emotional [ ] Autism [ ] Adult retardation [ ] Dementia

[ ] OBS [ ] Alzheimer's [ ] Developmental disability [ ] Other _____

(Please attach EEG or neuropsychological evaluation showing full scale intelligent quotient "FSIQ" or mental age, as applicable.)

b. Level of mental impairment: [ ] Mild [ ] Moderate [ ] Severe [ ] Profound, I.Q.:_____

5. UNCONTROLLED FATIGUE: ***(Must Specify)***

a. [ ] Radiation/Chemo b.[ ] Dialysis If either a. or b. is marked please provide the following:

Treatment Schedule (or duration): _____ Treatment Start & expected End date: _____ thru _____

Treatment Center: _____ Address: _____

c.[ ] HIV (Please attach Elisa, Western Blot result reading CD4+ counts.) **d.[ ] Other _____**

6. IMPAIRMENT RELATED CONDITION:

a. [ ] Arthritis (Please attach MRI/CAT/X-ray findings or operative reports of area affected)

{Functional Classification ____ Anatomical Stage ____} b. [ ] Other_____

b. [ ] Cardiac (Please attach EKG or operative findings) _____

{Functional Classification ____ Therapeutic Classification ____} _____

c. [ ] Respiratory *(Must specify)* {FVC ____ FEV1 ____} (Please attach oxymetric capability report)

C. DESCRIBE IN DETAIL THE APPLICANT'S PRIMARY DISABILITY: ***(BE SPECIFIC)***

_____

_____

_____

D. IS THIS DISABILITY: [ ] Perm [ ] Temp; (If temporary, date of disability _____, & length of recovery _____)

E. IS THIS DISABILITY CONTROLLED BY MEDICATION? [ ] Yes [ ] No

Explain:_____

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F. INDICATE THE TASKS RELATED TO USING PUBLIC TRANSIT THAT THE APPLICANT WOULD FIND <u>IMPOSSIBLE</u> (NOT DIFFICULT) TO DO. CHECK ALL THAT APPLY:

[ ] No limitations that would prevent the use of bus/rail service
[ ] Boarding vehicle without a wheelchair lift
[ ] Enduring common weather conditions
[ ] Identifying a public transit vehicle
[ ] Understanding/handling bus fare *(money)* transactions
[ ] Handling changes in normal routine
[ ] Walking more than _____ blocks *(Must stipulate number of blocks)*
[ ] Enduring warm weather
[ ] Waiting thirty minutes
[ ] Recognizing a bus stop
[ ] Recognizing destinations if stops are announced
[ ] Climbing 1-3 steps

These limitations apply: [ ] Always [ ] Usually [ ] Occasionally [ ] Rarely

G. MOBILITY AID: [ ]Wheelchair [ ]Walker [ ]Crutches [ ]Braces [ ]Service Animal [ ]None [ ] Cane [ ]Other _____

H. REQUIRED MODE OF TRANSPORTATION: Please indicate the type of transportation required by the applicant based on his/her functional ability.
[ ] Ambulatory (van, sedan) [ ] Wheelchair Transferable(van,sedan) [ ] Wheelchair Confined(lift van)

I. BASED ON THE INDIVIDUAL'S DISABILITY, DO YOU RECOMMEND HIM/HER TO BRING A PERSONAL CARE ATTENDANT ON EACH TRIP? [ ] Yes [ ] No

J. PLEASE ATTACH PERTINENT MEDICAL DOCUMENTATION (E.G. EVALUATIONS, TEST RESULTS, NOTES, REPORTS, ETC.) THAT WOULD HELP TO EXPLAIN THE DIAGNOSIS OR LIMITATIONS ON THE APPLICANT'S ABILITY TO USE METROBUS, METRORAIL, OR METROMOVER.

NOTE: Failure to attach documentation <u>will</u> delay the eligibility determination process and <u>will</u> require that MDT contact your office to obtain pertinent documentation before rendering a decision.

IN SIGNING, I ACKNOWLEDGE THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THIS EVALUATION FORM IS TRUE AND CORRECT. FURTHERMORE, I CERTIFY THAT, I HAVE ATTACHED OBJECTIVE MEDICAL TESTS/DOCUMENTATION WHICH SUBSTANTIATE THE ABOVE STATEMENTS. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION COULD RESULT IN THE RE-EXAMINATION OF THE ELIGIBILITY STATUS OF THE APPLICANT AS WELL AS PROSECUTION TO THE MAXIMUM EXTENT ALLOWED BY THE LAWS OF THE STATE OF FLORIDA.

[ ] YES, I have attached the required medical documentation

Print or Type Name of Physician **State of Florida License#** **Signature**

Office Address **City** **State** **Zip Code** **Telephone** **Fax #**

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